BEFORE THE APPEALS BOARD
FOR THE
KANSAS DIVISION OF WORKERS COMPENSATION

KENNETH W. ARNOLD	)	
Claimant	)	
VS.	)	
	)	Docket No. 1,001,211
LIFT, INC.	)	
Respondent	)	
AND	)	
	)	
BUILDERS' ASSOCIATION SELF-INSURERS' FUND OF KANSAS	)	
Insurance Carrier	)	

ORDER

Respondent appeals the July 15, 2003 Award of Administrative Law Judge Robert H. Foerschler. Respondent contends that claimant should have been awarded a 15 percent impairment to the body as a whole for the injuries suffered on October 1, 2001, and restricted from receiving payment for medical expenses incurred during the treatment for his low back injury. Respondent contends the medical treatment received by claimant was all unauthorized and respondent's liability is limited to the $500 unauthorized medical allowance.[1] Claimant contends that the Award should be affirmed, arguing claimant's back surgery was the result of an emergency situation and should be deemed authorized. The Appeals Board (Board) heard oral argument on January 13, 2004.

APPEARANCES

Claimant appeared by his attorney, Dennis L. Horner of Kansas City, Kansas. Respondent and its insurance carrier appeared by their attorney, Wade A. Dorothy of Lenexa, Kansas.

[1] K.S.A. 44-510h(a)(2).

RECORD AND STIPULATIONS

The Board has considered the record and adopts the stipulations contained in the Award of the Administrative Law Judge. In addition, the parties acknowledge that the transcript of preliminary hearing of March 8, 2002, was stipulated as part of the record in the regular hearing, pages 5 and 6. Although not listed in the Award, the Board will consider the transcript of preliminary hearing as part of the record for the purposes of this appeal.

ISSUES

(1) What is the nature and extent of claimant's injury?

(2) Are the medical expenses incurred by claimant for the injuries suffered on October 1, 2001, including the surgery of December 27, 2001, authorized or unauthorized medical expenses?

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Claimant suffered a work-related injury on October 1, 2001, while working as a crane operator for respondent. Claimant was moving timbers in order to level a crane when he suffered an injury to his low back. Claimant initially discussed the injury with his supervisor, Steven Bright, but requested no medical treatment. Claimant testified that he did not want workers' compensation to be involved in this matter, preferring to submit the bills under his regular health insurance. Claimant stated that "I just basically didn't want to get into a work comp type situation to where I'd have to take off work."[2]

Claimant sought unauthorized medical treatment. However, claimant's condition was serious enough that the chiropractor, Dr. Green, would not treat him. Claimant then went to Dr. Martin, his family physician, who also could not help his condition. Claimant was then examined and treated by orthopedic surgeons Jeffery B. Weaver, M.D., and Daniel M. Downs, M.D., of Jackson County Orthopedics, Inc. Claimant underwent epidural injections and physical therapy, both proving unsuccessful. As of December 20, 2001, claimant was advised by Dr. Weaver that the only option remaining would be a surgical decompression for his spinal stenosis.

Claimant continued discussing his situation with his foreman, Mr. Bright, but continued to seek unauthorized medical treatment through his health insurance company,

[2] P.H. Trans. at 14.

refusing to file a workers' compensation claim. Shortly after the December 20, 2001 examination with Dr. Weaver, claimant's condition began to substantially worsen. By the time claimant was examined by Dr. Downs on December 26, 2001, he was having severe back and leg pain.

Claimant had earlier undergone an MRI showing dessication of the discs at L3-4, L4-5 and L5-S1, with disc prominence at L3-4 with right lateral extension and also at L4-5. The L5-S1 discs were degenerated, although not significantly narrowed.

Claimant was referred for a myelogram by Dr. Downs. Dr. Downs advised claimant that his condition was serious and getting worse, as the myelogram showed a moderate size disc herniation at L3-4, which, in Dr. Downs' opinion, was having a seriously negative effect on claimant's low back and lower extremities. Dr. Downs advised that claimant have immediate surgery, which claimant underwent on December 27, 2001, involving a decompressive laminectomy at L3-4 and an L4-5 disc decompression. Dr. Downs testified that during the surgery, he discovered the L4 nerve root was severely flattened as the result of a large disc herniation.

After surgery, claimant underwent additional treatment and was ultimately returned to work with respondent with restrictions. Respondent was able to accommodate claimant's restrictions, and he is back to work at a comparable wage.

Dr. Downs opined that claimant had a 20 percent impairment to the body as a whole pursuant to the American Medical Ass'n, *Guides to the Evaluation of Permanent Impairment* (4th ed.), using both the DRE and range of motion models from the AMA *Guides*. He stated that there was a possibility claimant might have a 25 percent impairment, but found this to be somewhat speculative, opting to limit claimant's impairment to the 20 percent to the body as a whole rating.

Claimant was examined by board certified orthopedic surgeon Truett L. Swaim, M.D., at claimant's attorney's request on October 7, 2002. Dr. Swaim also opined at his deposition that claimant had a 20 percent impairment to the body as a whole based upon the AMA *Guides* (4th ed.), using the DRE model. He also stated that a 25 percent impairment was possible, but elected not to assess claimant that impairment. He testified that with claimant's problems, a DRE level III of 10 percent to the body as a whole was not sufficient to fully rate the condition. During his examination, Dr. Swaim noted atrophy in claimant's right leg, both at the thigh and calf level, which he stated was from the back injury.

Claimant was examined by board certified orthopedic surgeon Jeffrey T. MacMillan, M.D., at the request of respondent on January 17, 2003. At that time, claimant continued with numbness and paraesthesia of the right leg and foot. Claimant was unable

to heel walk on the right side. Dr. MacMillan assessed claimant a 10 percent impairment to the body pursuant to the AMA *Guides*, finding claimant had a level DRE III impairment. However, it is noted that Dr. MacMillan did not mention atrophy, even though Dr. Swaim had earlier noted it in his records. Dr. MacMillan acknowledged that thigh atrophy would be consistent with an L3 root lesion and calf muscle atrophy would be consistent with an L5 or S1 root lesion. He agreed he did not measure the muscle in the leg during his examination. He was asked if incapacitating pain, even while claimant was on OxyContin and Percocet, would be a significant finding. He acknowledged that surgery was probably the correct choice under those circumstances.

In workers' compensation litigation, it is claimant's burden to prove his entitlement to benefits by a preponderance of the credible evidence.[3]

The Board finds that claimant has suffered a 20 percent impairment to the body as a whole based upon the opinions of Dr. Downs and Dr. Swaim. It is understood that Dr. MacMillan's opinion is lower, but the Board has concerns with Dr. MacMillan's opinion, noting that he did not measure the muscles in the leg and, therefore, could not verify or deny the existence of atrophy. Dr. MacMillan did go on to state that atrophy, in both the thigh and the calf, would be consistent with the L3 and L5-S1 root lesions, which were conditions diagnosed of claimant. The Board finds the opinions of Dr. Downs and Dr. Swaim to be the more credible and affirms the Administrative Law Judge's 20 percent impairment to the body as a whole.

A significant issue involves the matter of the medical expenses incurred by claimant. Claimant testified that he did not request medical treatment from respondent and, in fact, was against utilizing workers' compensation because it would require that he take time off work, which he wanted to avoid. Claimant's request for medical treatment from respondent did not occur until substantially after the December 27, 2001 surgery had occurred.

The Workers Compensation Act compels a respondent to provide medical treatment that is reasonably intended to cure and relieve an injured employee of the effects of a compensable injury.[4] With that obligation comes the right to designate the authorized treating physician. Only when a respondent fails and/or refuses to provide medical treatment is a claimant permitted to select a physician to direct his or her care.[5]

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[3] K.S.A. 44-501 and K.S.A. 2001 Supp. 44-508(g).

[4] K.S.A. 44-510h(a).

[5] K.S.A. 44-510h(b)(1).

The Workers Compensation Act requires the employer to provide such medical services that may be reasonably necessary to cure and relieve an injured employee from the effects of an injury. The Act provides:

> It shall be the duty of the employer to provide the services of a health care provider, and such medical, surgical and hospital treatment, including nursing, medicines, medical and surgical supplies, ambulance, crutches, apparatus and transportation to and from the home of the injured employee to a place outside the community in which such employee resides, and within such community if the director, in the director's discretion, so orders, including transportation expenses computed in accordance with subsection (a) of K.S.A. 44-515 and amendments thereto, **as may be reasonably necessary to cure and relieve the employee from the effects of the injury**.[6] (Emphasis added.)

But if the employer refuses or neglects to provide medical treatment, the employee may obtain medical treatment and the employer is liable for that expense. The Act reads:

> . . . **If the employer has knowledge of the injury and refuses or neglects to reasonably provide the services of a health care provider required by this act**, the employee may provide the same for such employee, and the employer shall be liable for such expenses subject to the regulations adopted by the director. . . .[7] (Emphasis added.)

The Board agrees with the Administrative Law Judge's conclusion that claimant's surgery was performed under a sense of urgency as to justify treating it as an emergency.[8]

Moreover, respondent knew of claimant's injury, knew it was work related and knew claimant was receiving medical treatment for the injury. Nevertheless, respondent never sent claimant to be examined and treated by a physician of its choosing. Instead, respondent was content to allow claimant to pursue medical treatment on his own. It is disingenuous for respondent to now argue that it should not be responsible for the cost of claimant's treatment because to do so would deny respondent its right to control the medical treatment. Respondent could have directed claimant to a physician of respondent's choosing at any time once it received notice of claimant's work-related injury.

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[6] K.S.A. 44-510h(a).

[7] K.S.A. 44-510j(h).

[8] *See* 5 *Larson's Workers' Compensation Law* § 94.02[6] (2003).

Under these circumstances, claimant's medical treatment expenses should be ordered paid as authorized.[9]

AWARD

WHEREFORE, it is the finding, decision, and order of the Appeals Board that the Award of Administrative Law Judge Robert H. Foerschler dated July 15, 2003, should be, and is hereby, affirmed.

IT IS SO ORDERED.

Dated this ____ day of February 2004.

BOARD MEMBER

BOARD MEMBER

BOARD MEMBER

DISSENT

In this instance, both claimant and respondent knew claimant had suffered a work-related injury. Claimant, however, consciously chose to proceed outside the confines of the Kansas Workers Compensation Act and direct his own treatment. While it is true respondent did not offer medical treatment to claimant, it is also clear from claimant's own testimony that such an offer would have been unwelcome. Claimant desired to continue working, earning substantial wages including overtime, not wanting to risk the loss of income that may have resulted with the filing of a workers' compensation claim. While claimant's concerns are understandable, claimant's decision does come with consequences.

[9] *See Houston v. Kansas Highway Patrol*, 238 Kan. 192, 708 P.2d 533 (1985).

K.S.A. 44-510h(b)(2) allows an employee to consult with a health care provider of the employee's choice for the purpose of examination, diagnosis or treatment, "but the employer shall only be liable for the fees and charges of such health care provider up to a total amount of $500."

Under these facts and circumstances, this Board Member would find that claimant's decision to proceed outside the Act renders his medical treatment as "unauthorized" medical. This Board Member understands the allegations by claimant that the surgery of December 27, 2001, was a "medical emergency." However, claimant was aware for nearly three months that he was having significant problems as a result of the October 1, 2001 injury. Additionally, claimant was advised by Dr. Weaver on December 20, 2001, that surgery was the only remaining option, as his earlier attempts at conservative treatment had proven unsuccessful. Despite all of this information, claimant failed to request treatment under the Workers Compensation Act until well after the surgery had been performed. The need for surgery does not alter the fact that claimant's treatment was unauthorized medical care. The outstanding medical bills should be deemed unauthorized and subject to the $500 allowance set forth in K.S.A. 44-510h.

BOARD MEMBER

c: Dennis L. Horner, Attorney for Claimant
Wade A. Dorothy, Attorney for Respondent and its Insurance Carrier
Robert H. Foerschler, Administrative Law Judge
Paula S. Greathouse, Workers Compensation Director